MR SCREENING PROCEDURE FORM

- Date: _____
- Name:_____ Sponsor's Social Security No.:_____
- Phone numbers: Home: _____ Work: _____
- Height: _____ Weight: _____ Sex: M F Age: _____
- Reason for MRI: _____
- _____

The following **items may interfere** with Magnetic Resonance Imaging (MRI). Some of these items **may also be Hazardous** to your safety. Please check the appropriate response for each of the items listed below.

YES	NO		YES	NO	
____	____	Defibrillator	____	____	Cardiac Pacemaker
____	____	Intravascular coil, filter, stent	____	____	Aneurism Clips
____	____	Shrapnel, foreign body, bullet	____	____	Electrodes
____	____	Venous Umbrella	____	____	Hearing Aids
____	____	Metal Fragments in Eyes, Head or Skin	____	____	Insulin Pump
____	____	Prosthesis, artificial limb, or joint	____	____	Dentures
____	____	Cochlear Implants – Inner or Middle Ear	____	____	Heart Valve
____	____	Neurostimulator – Tens Unit	____	____	Penile Prosthesis
____	____	Metal Plates, Pins, Screws, Nails or Clips	____	____	Metal Mesh Implants
____	____	Shunt – Spinal or Ventricular	____	____	Tattooed Eye Liner
____	____	Fractured Bones Repaired with Metal Rods	____	____	Diaphragm, IUD or Pessary
____	____	Heart Catheter	____	____	Piercing
____	____	Intravascular Access Port			

* Any other implanted item: _____
* Are you Claustrophobic? _____Yes _____No
* If female, is there any possibility of pregnancy? ____Yes ____No
* Have you worked in the presence of metallic shavings? (i.e., welding, machine shop, oil fields, BB shrapnel, grinding, etc.) ____ Yes ____ No
* Do you have any drug allergies, kidney disease, asthma or allergic respiratory disease? ____ Yes ____ No If yes please explain. _____
* Have you ever had a reaction to contrast medium for MRI or CT? ____Yes ____ No

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's signature: _____

MD/RN/RT signature: _____ Date: _____

Print MD/RN/RT name: _____